PHYSICAL IMPAIRMENT/DISABILITY REPORT

Client Name	Social Security Number	Client ID#

TO THE HEALTH CARE PROVIDER:

This person is being evaluated for Medicaid Disability Benefits. We need medical evidence about the nature of his/her medical condition, and the severity of the associated impairment.

We are not asking you to make the disability decision. The disability determination is made by our Medical Review team. However, we are asking you to supply us with the medical information we need to make the decision.

Ideally, this form should be completed by the TREATING PHYSICIAN based on his/her knowledge of the individual, using existing treatment and progress records and results of previous evaluations, as well as current observations. **If this person has no treating physician, or has not been seen recently**, please perform a current examination.

A narrative report which provides the same information may be substituted for this form.

DO NOT give the report to the client. **Return the completed report to the worker.**

Worker's Name **Department**	**Worker's Address**	Worker's **Phone #**

TO THE WORKER:

This form should be sent to the person who <u>treats</u> the client for his PHYSICAL problems. If the client has a mental impairment, a form 20M should be sent to his/her psychiatrist, instead of this form.

NOTE: Completed form/report should not be given to the client. Please **include a pre-addressed return envelope** that the provider can use to return the completed form/report in. Include your name, address and telephone number above, so the provider can contact you if necessary.

Include a completed form **MI 706 Request for Medical Information** with the form 20. The doctor will use the MI 706 for payment purposes. If the doctor requests additional evaluations or testing before completing the form 20, refer him/her to the instructions and phone number on the back of the MI 706.

COMPLETING THE FORM 20

WHAT INFORMATION DO WE NEED?

- **!** Patient's Allegations and Symptoms;
- **!** A history of treatment and progress;
- **!** Medication and Ongoing Therapies;
- **!** Current Examination Findings to include:
- **!** Detailed description of the clinical signs and laboratory findings;
- **!** Detailed description of associated functional impairments.

ALLEGATIONS:

Summarize the patient's allegations of symptoms, limitations and restrictions.

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_____

_____

HISTORY:

NOTE: A history based on your knowledge and records is far more useful than a subjective report by the patient. Please describe onset and initial status, treatment and progress. Describe remissions, exacerbations, complications.

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MEDICATIONS AND ONGOING THERAPIES:

_____

_____

_____

CURRENT EXAMINATION FINDINGS:

This reporting form is divided into major system/disease categories. Please complete the sections which correspond to the conditions for which you are treating the patient, in detail. **If your patient alleges new or additional conditions or symptoms, is a new patient, or hasn't been evaluated recently**, please perform an examination and include the clinical findings relevant to the alleged symptoms and conditions. If you have copies of other reports and test results, please include copies.

” MUSCULOSKELETAL SYSTEM

For each area involved, describe deformities, e.g., subluxation, contractures, ankylosis, instability, deviation, etc.. Include range of motion and a description of upper and lower extremity function, grip strength, dexterity, gait. In cases of inflammatory joint disease, include a brief history of onset, treatment, remissions, exacerbations. For spinal disorders, include a description of any weakness or motor loss, muscle spasm or atrophy, as well as any sensory or reflex abnormality. Describe nature, location and severity of pain. Include radiology reports and laboratory findings (sed rate, RA latex, etc.).

” NEUROLOGICAL

Describe the nature and severity of condition. _____

Indicate the associated clinical manifestations:

___ Motor dysfunction;	____Reflex abnormalities;	____Sensory loss;	___ Spasm;
___ Muscle Weakness;	___ Disturbance of Balance;	___ Atrophy;	___ Tremors;
___ Neuropathy;	___ Coordination Problems;	___ Paralysis;	___ Epilepsy;
___ Aphasia;	___ Cognitive Impairment;	Other (Specify) _____	

Describe the above in terms of their impact on your patient’s ability to function. Describe gait, ability to use upper extremities for fine and dexterous movements and gross motor functions. Describe any impairment of mental functioning, ability to care for his/her self, ability to communicate, understand and follow instructions, remember, etc.. Comment on fatigue, weakness, disorganization of motor function, rigidity, tremor, etc._____

Describe the typical seizure pattern, including frequency, nature, severity, duration and postictal period. Is patient compliant with medication, abstinence from alcohol, etc? _____

Please include copies of tests and lab findings, EEG's, consultation reports, and hospital records.

” SPECIAL SENSES AND SPEECH

Please describe any abnormalities of the eye structure and function. Include best corrected visual acuity from eye chart and evidence of constriction of peripheral fields. Please describe patient's ability to read, distinguish objects at a distance, drive, etc. _____

_____

_____

Describe the patient's ability to hear and understand normal conversational speech. Include results of hearing testing. _____

_____

Describe any signs or symptoms of vestibular dysfunction, such as loss of balance, tinnitus, progressive hearing loss. Include results of hearing and caloric testing, or other vestibular function tests.

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_____

Is the patient able to produce sustained, understandable speech? Describe the quality of speech.

_____

_____

” CARDIOVASCULAR SYSTEM

Describe the nature and severity of abnormalities or diseases and include history of treatment and response. Include results of chest x-ray, catheterization, angiography, echocardiograms, exercise testing, etc..._____

_____

_____

Chest pain? Describe: precipitating factors, location, nature, severity, radiation, duration. What relieves the pain?_____

_____

_____

Blood Pressure:_____; Pulse rate _____; Edema Yes _____ No _____. Pitting? _____
Describe: _____

Congestive failure? Describe signs: _____

_____

Dyspnea? What causes it? How severe is it? _____

_____

Circulation problems: Describe signs of venous insufficiency (edema, varicosities, stasis dermatitis, ulceration), arterial blockage (claudication, absent pulses). Include results of venogram, arteriogram, Doppler study, etc. _____

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_____

” RESPIRATORY SYSTEM

Describe history of disease process and breathing problems. Describe breath sounds, labored breathing, hyperexpansion of chest, dyspnea, cyanosis or clubbing. Indicate the nature and level of exertion that produces serious dyspnea. Can respiratory function be significantly improved with treatment? Include results of chest x-rays, pulmonary function studies, blood gas studies, etc..

For respiratory impairments which are episodic in nature (asthma, bronchitis), describe the frequency of severe episodes (prolonged episodes lasting several hours, requiring intravenous drugs or inhalation therapy in a hospital or emergency room). Describe response to treatment.

” DIGESTIVE SYSTEM

Does the patient have G.I. bleeding, weight loss, chronic diarrhea, swelling, tenderness? Is there evidence of inflammation, obstruction, abscess or fistula formation? Are there signs of liver enlargement, dysfunction? Include results of blood tests, copies of endoscopy reports.

Height_____ **Weight**_____(From in-office measurements please)

” GENITO-URINARY SYSTEM

Does the patient suffer from chronic renal disease or nephrotic syndrome? Include exam findings (edema, weight loss, vascular congestion, etc.) as well as laboratory results._____

Is the patient currently receiving dialysis? Yes____ No _____. If yes, date started _____.
Has patient had a kidney transplant? Yes____ No _____. If yes, date of transplant_____.

Current status? Include current lab findings. _____

” HEMIC AND LYMPHATIC SYSTEM

Describe the nature and severity of condition (anemia, leukemia, coagulation defects, myeloma, chronic or repeated infections, etc.) and include clinical and laboratory evidence, pathology results. _____

” ENDOCRINE SYSTEM

Describe the nature and severity of condition and any resulting structural or functional changes. The resulting impairment may be more appropriately described under the particular body system (as in the case of diabetic nephropathy, neuropathy, or retinopathy). _____

Obesity: Height _____ Weight _____ (From in-office measurements please)

” NEOPLASTIC DISEASES

Please describe the nature and location of primary tumor, extent of involvement of surrounding structures. Indicate any metastatic disease. Describe treatment and response. Any signs of recurrence? Include copies of pathological/biopsy reports, x-ray reports, operative reports, etc. Describe the nature and severity of associated impairment, effects of surgery, radiation or chemotherapy.

” IMMUNE SYSTEM DISORDERS

These conditions result from impairment of the immune system, and can include: Connective tissue disorders (lupus, systemic vasculitis, sclerosis and scleroderma, polymyositis, and inflammatory joint disease); Allergic disorders; and, AIDS. Please describe the nature and severity of the condition, the involvement of body systems and organs, and the associated limitations and restrictions. Include clinical, laboratory and biopsy reports. Indicate disease process, response to treatment, recurrences and exacerbations, complications. _____

” MENTAL DISORDERS

Please indicate any of following which apply to your patient.

AFFECTIVE STATUS AND REALITY CONTACT:

___ Anxiety ___ Depression ___ Suicidal Ideation ___ Mania
___ Panic Disorder ___ Phobias ___ Somatization ___ Grandiosity
___ Paranoia ___ Delusions ___ Hallucinations ___ Homicidal Ideation
___ Obsessive Compulsive Disorder ___ Personality Disorder

ATTITUDE AND BEHAVIOR:

___ Pleasant ___ Relaxed ___ Tearful ___ Fearful ___ Hostile
___ Withdrawn ___ Guilt ___ Insomnia ___ Tremors ___ Mood Swings
___ Hysterical Outbursts ___ Antisocial Behavior ___ Explosive Behavior

Please describe in detail the problems and behaviors indicated above. How frequently do they occur and how do they affect patient's ability to function? Indicate response to treatment and current status?

Indicate the degree of help or direction needed to properly perform activities of daily living, e.g., personal hygiene, finances, shopping, work, driving, etc.

Describe how patient gets along with and communicates with family members, neighbors, friends, fellow employees, supervisors, etc.

INTELLECTUAL FUNCTIONING/SENSORIUM:

Please describe and provide specific examples of orientation, memory, concentration, signs of organicity, judgment, etc. If intellectual functioning or organic involvement have been measured with standardized tests, please include test results including dates of testing.

PAIN and FATIGUE

Limitations and restrictions can result from the pain and fatigue associated with various injuries and disease processes.

If the patient complains of pain, **describe**: the nature, location, intensity and duration; what causes the pain, or worsens it; what relieves the pain._____

_____

_____

If the patient alleges abnormal levels of fatigue, **describe**: the nature, intensity and duration of fatigue; what causes or worsens the fatigue, and what relieves it; how it limits, restricts, or alters activities.

_____

_____

CONCLUSIONS

DIAGNOSES: _____ _____

_____ _____

_____ _____

PROGNOSIS:

Is the condition static?	**G** Yes	**G** No_____
Can improvement be expected?	**G** Yes	**G** No_____
Will condition grow worse?	**G** Yes	**G** No_____

LIMITATIONS: Describe any mechanical, exertional, or environmental limitations or restrictions in terms of his/her ability to: sit, stand, walk, stoop, bend, lift, carry, use arms and hands for repetitive fine and gross movements, etc: Does he/she **require** a cane, crutches, walker, or a wheelchair.

_____

_____

RECOMMENDED TREATMENT: _____

_____

_____

ADDITIONAL COMMENTS OR RECOMMENDATIONS: _____

_____

_____

_____

Date of Last Exam _____

_____ _____

Signature of Physician Date of report

_____ _____

Printed name of Physician Phone Number